Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY IMGAGING CENTER
PO BOX 29490
SAN ANTONIO TX 78229

Respondent Name
VIA METROPOLITAN TRANSIT

Carrier's Austin Representative
Box Number 16

MFDR Tracking Number
M4-13-0681-01

MFDR Date Received
NOVEMBER 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient stated services which were provided were covered under worker's compensation claim. 08/20/2012 We received EOB denying our claim based on no authorization. (SEE ATTACHMENT B) 09/25/2012 We mailed a request for reconsideration. (SEE ATTACHEMENT C) 10/11/2012 WE received an EOB denying our request for reconsideration.. [sic] (SEE ATTACHMENT D)"

Amount in Dispute: $1,159.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed is a copy of the April 23 and April 26, 2013 pre-authorization request from Rubie at South Texas Radiology Imaging requesting MR arthrogram of left hip. Also enclosed is the April 27, 2012 pre-authorization notification stating services were 'non authorized'."

Response Submitted by: Argus, 811 S. Central Expwy, Suite 440, Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2012	CPT Code 27093 – Injection procedure for hip arthrography; without anesthesia CPT Code 77002 – Fluoroscopic guidance for needle placement CPT Code 73722 – Magnetic resonance imaging, any joint of lower extremity; with contract material(s)	$1,159.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 39 – Services denied at the time authorization/pre-certification was requested.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor obtain preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Labor Code §134.600(p)(8)(A)(B), "Non-emergency health care requiring preauthorization includes: unless otherwise specified in this subsection, a repeat individual diagnostic study; with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or without a reimbursement rate established in the current Medical Fee Guideline." Review of the documentation submitted by both parties finds that the injured employee had a previous MRI on April 15, 2011. The requestor states that "**Authorization was obtained as reasonable & necessary. (see attachment A)**.

   The respondent submitted copies of the April 23 and April 26, 2012 preauthorization request and the pre-authorization report and notification, dated April 27, 2012, which documents a pre-authorization determination of non-authorized.
2. Review of the submitted documentation finds that the healthcare provider requested preauthorization; however, this request was not authorized for the repeat MRI; therefore, the requestor is not eligible for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 30, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.